

The Lewin Group
Diagnosing and Treating Dementia -- Current Best Practices
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Caroline Loeser: Thank you. My name is Caroline Loeser. I'm with the Lewin Group. Welcome to the webinar, Diagnosing and Treating Dementia -- Current Best Practices. Today's session will include a 60-minute presenter-led discussion followed up with 30 minutes for a discussion among the presenters and participants.

This session will be recorded, and a video replay and copy of today's slides will be available at <https://resourcesforintegratedcare.com/>. The audio portion of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access that number, click the black phone widget at the bottom of your screen.

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For today's webinar, the planners and faculty have no relevant financial interests or affiliations. You'll see on this slide that we've laid out the various continuing education credit requirements. Social workers can obtain continuing education credit through NASW if they complete the pre-test at the beginning of the webinar and complete the post-test.

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At this time, it is my pleasure to introduce the faculty for today's webinar. Dr. David Reuben is Chief of the Division of Geriatrics and Archstone Foundation Professor at the David Geffen School of Medicine at UCLA. He is also Director of the UCLA Alzheimer's and Dementia Care Program.

Dr. David Bass is Senior Vice President, Senior Research Scientist, and Director of the Center for Research and Education at the Benjamin Rose Institute on Aging. His research on evidence-based programs for persons with Alzheimer's disease or other dementias and their family caregivers has led to the development of innovative programs for older adults and their family members.

Ms. Michelle Panlilio is a Nurse Practitioner and Dementia Care Specialist at UCLA at the Alzheimer's and Dementia Care Program. As a Dementia Care Specialist, she manages a panel of 300 individuals with various types of dementia and is responsible for developing and implementing individualized dementia care plans based on the needs of each person with dementia and their caregivers.

And Ms. Ann Cheslaw has been a part of the UCLA Patient and Family Advisory Committee at UCLA and has been an important voice for caregivers caring for a loved one with dementia. Ms. Cheslaw cared for her mother with dementia for two years.

And on the next slide, we have our learning objectives for today's webinar. Today, we will discuss best practices and guidelines for screening, diagnosis, and assessment of dementia. We'll go into some detail about current evidence-based treatment options for dementia. And we will also hear about the importance of family caregivers. And we'll discuss the roles and strategies for community-based organizations and health systems in supporting older adults with dementia and their caregivers.

And on the next slide, we have the agenda for today's webinar. To start off, we will begin with two poll questions to get to know the audience a bit more. We want to move into the polls. The first question is, in what setting do you work? So, we'll give the audience just a couple seconds now to select the setting that will work, and then, we'll push the results.

Great. Well, it looks like a little over half of us here work for health plans. We also have some ambulatory care settings. Long-term care facilities. Some community-based organizations. Looks like we have a nice range. Great. Welcome, everyone.

And the next poll question is, which of the following best describes your professional area? All right. And then, we'll go ahead and push the results. Great. It looks like we have about a third of health plan case management and care coordinators. Some health plan administrative staff. Social work. Great. Welcome, everyone.

All right. Well, thanks, everyone, for sharing. At this point, I will pass it off to Dr. Reuben.

David Reuben: Good morning. Thank you very much. Next slide, please. So, the first slide here actually has the faces of five very famous people. And what do these people all have in common? They all have dementia. And this is just a way of putting a face to a terrible, terrible disease that nobody is spared of. Next slide, please.

What is dementia? In 2011, the National Institute on Aging came up with a new definition of dementia. And that required that it was an acquired, chronic decline in cognition. It was not

explained by either a delirium, which is an acute confusional state, or a psychiatric disorder. And it had to have dysfunction in at least two domains.

The first is memory. That's laying down and recalling information. Reasoning and handling of complex tasks. This is what we call executive function. The kind of planning that we do. The third is visuospatial impairment. And that's being able to recognize sometimes faces and sometimes objects. And then, impaired language function. That's naming things. That's being able to process conversations. And then, changes in personality or behavior.

So, these are the five areas that are affected by dementia. It used to be, before 2011 definition, that memory had to be a feature but no longer. Just has to have two out of the five. And then, the other key component that is absolutely necessary is that these disorders of cognition need to get in the way. They have to affect somebody's daily life and daily function. Next slide, please.

When I'm teaching students, I like to refer to dementia as the gray plague. And it is a disorder of aging. So, between the ages of 65 to 74 years of age, roughly 3% to 5% of the population has dementia. But as people get older, particularly that 85 and older age group, that the prevalence ranges between 35% and about 50%.

And that means that the likelihood is that by the age of 85 or older, that either you, or your spouse, or your brother, or your sister will have this disorder. And I would be willing to guarantee that if we live long enough, that everybody on this call will be affected by this disease.

So, people ask me a lot, what's the difference between dementia and Alzheimer's disease? Dementia is the overriding term. The umbrella term. And Alzheimer's disease is by far the most common form of disease. Other forms are vascular dementia. That's usually small strokes. Dementia with Lewy bodies, or with Parkinson's disease. But these are relatively uncommon. Next slide, please.

This disease is an exceptionally common disorder. About 5.8 million Americans currently have it. And that's more than the number of Americans who have heart failure. And this is expected to triple between now and 2050. It affects people of all ethnicities, but Latina and African-American seem to be affected more commonly. A bit more commonly. And about a quarter of people who are affected are dually insured.

This has a tremendous economic burden. Not only on the healthcare system, but on unpaid caregivers, who provide over 80% of the care and at tremendous to their own personal lives. You'll hear more about that in a bit. Next slide, please.

I like to think about Alzheimer's disease in specific, the most common, as a two-phase strategy. And thinking, looking first to the right-hand side of the slide, where we think about 2030. And this is where all of the research or much of the research is going into. By that point, 7.7 million Americans will have dementia. And at that time, we will have a way of identifying people who are at risk of developing dementia. And this likely will be a blood test. And you think about this as an analogy to coronary heart disease, where you can get a cholesterol level that's a predictor. And already, there're some candidates and some tests that're being developed.

And similarly, not only to identify the risk factor, but also be able to monitor whether somebody is converting from having the risk factor to actually having the disease. We hope to have good preventive strategies. We will be able to detect Alzheimer's disease. We hope to have better treatments. And still, there will be a lot of need for support for both patients and caregivers.

But going to the left-hand side of the slide, where we are now with 5.8 million Americans with dementia, what we have is detection. We have some good ways to detect dementia. We'll talk about those in a few moments. We have treatments that aren't very effective. And we have a tremendous need for support. Next slide, please.

So, beginning with detection, the first step is screening. And this is taking people who're kind of all comers and identifying that something is not right. There're many ways to do this that are well validated. Some of the simple ways are three-item recall, where you ask them to recall three words. You distract them and talk about something else. And then, you ask them about the three words again.

One way of doing this is an instrument called a Mini-Cog, which is basically a three-item recall sandwich. And in the middle of the sandwich is a clock that you ask the patient to draw. There're several others. One is the Mini-Mental State Examination, the Montreal Cognitive Assessment, which is also called the MoCa, and dozens more.

The good news about these tests is they all are pretty good. They're all pretty good at identifying people who have something wrong. Who have dementia. But they do not establish a diagnosis. So, if somebody fails one of these tests, you can't say they absolutely have dementia.

In 2014, the US Preventive Services Task Force came out with a paper. And that paper weighed the benefits and harms of screening. The conclusion they came to was they could not come up with a firm recommendation, because the evidence base wasn't there.

Now, this does not mean that you should not screen for dementia. But it also does not mean that you absolutely should. So, it's much more kind of an individual practice and an individual case-by-case determination. Next slide, please.

So, going from having an increased suspicion, failing a screening test is -- to make the diagnosis, you need the clinician's examination. So, the clinician's examination needs to go into some historical items such as when did the symptoms begin and what were the symptoms. They forgot to pay bills. They missed some appointments. They have repeated questioning. They don't seem to be retaining some things. They're becoming more irritable. Those kinds of things.

And you specifically want to ask about behavioral complications. Are they having agitation? Are they having trouble with sleeping? Are they irritable? Are there some personality changes? And then, you have to ask about functional status. Are they able to perform their daily activities? Things they used to do. And here, that's a key point. Things they used to do. So, if they've never cooked before, asking them about cooking may not be quite so relevant.

Then, the clinician needs to do a neurologic examination. This can be relatively brief. You want to look for findings that might indicate a previous stroke, such as asymmetries or weakness. You want to examine the gait, looking for asymmetry. And partially, this is to try to prevent complications such as falls that we see commonly with dementia. And then, you want to do a brief assessment for Parkinson's symptoms, because that can be one of the causes of dementia. Next slide, please.

So then, the clinician needs to do a mental status examination. And this is exceptionally important. It's really critical in making the diagnosis. So, you want to test somebody's memory. And that includes recall of items, similar to the three-item recall. But also, I like to ask about current events. And these are current events not that are not particularly esoteric, but that everybody would know.

One of the things I also like to do is I like to go through a little bit of politics. Who's the president? Who is the vice president? Things that people their age should know. And then, I also like to go to some more what we call remote memories. And that remote memory, I typically like to look for over learned behaviors or over learned memories.

So for example, one of the things I'll do is I'll ask them what happened to President Kennedy. And he was assassinated. Where was he assassinated? In Dallas. Who assassinated him? Lee Harvey Oswald. What happened to Oswald? He was assassinated. Who assassinated him? Jack Ruby. This is almost like having a dipstick to determine how deep their memory goes. The 9/11 attack, Pearl Harbor. There're a number of examples that I tend to use.

Language and fluency. So here, we do a test, it's very easy to do, called the animal naming test. And we pretend that we're sending somebody to a zoo, or a jungle, or a farm, and ask them to name as many animals as they can in one minute; 18 is normal. If people are below ten, it's really a source of concern.

Problem solving. This is an executive function. So, I pretend I'm going to send them to the grocery store. I want them to buy bread for me. The bread is \$0.75 a loaf. I want them to buy two loaves. I'm going to give them \$2.00. How much change do they get back? Then, I send them to the fish counter. And I ask them to buy salmon, which is \$8.00 a pound. I want them to buy a half a pound. I give them \$5.00. The key to this is always use the same example or else you'll get tripped up.

I also have them do a clock drawing test. And that is very valuable, both for executive function in terms of planning where the numbers are going, and also the visuospatial. Typically, what'll happen is when people make mistakes, it'll be in that upper quadrant between 9:00 and midnight. They'll either have too many numbers remaining, or they'll run out of numbers because of poor planning.

And then, there are some instruments that you can use to identify complications. The neuropsychiatric inventory identifies behavioral symptoms and caregivers' responses to them. And then, the Cornell scale for depression in dementia can identify how severe persons with the disorder's depression is. Next slide, please.

So, I would say that in roughly 80% of the people I see and evaluate for dementia, my clinical examination is sufficient. And I can pretty well make the diagnosis. But there's another 20% or so that I can't. They may either have been very, very high functioning, brilliant people, and I just can't be sure.

So then, I would send them for neuropsychological testing, which are similar kinds of tests, but they're longer and more difficult. And here, these are exceptionally valuable, both in making the diagnosis, but also establishing where the deficits are and where the strengths are. And sometimes they can also give you patterns to what the cause of the dementia is.

We also order lab tests. And these are primarily to exclude conditions that may look like dementia but probably aren't dementia but they may be contributing to cognitive impairment. And these include a complete blood count, a comprehensive metabolic panel, thyroid test, and B-12 test, and only among those people who have specific risk factors for syphilis or HIV, those would be tested as well. Next slide, please.

The next category of diagnostic testing are neuroimaging and cerebrospinal fluid testing. And that requires a spinal tap or lumbar puncture for the CSF testing. Neuroimaging is really the purview of the primary care physician. They can order those tests. But typically, the CSF testing is only done after a consultation with a neurologist.

The neuroimaging, these are the imaging of the brain, are most useful for people who develop early-onset dementia below the age of 60 or if they have a focal deficit, such as weakness on one side or another, or abrupt onset or rapid decline, or other predisposing conditions, such as cerebrovascular disease, or cancer, or they're on blood thinners.

The two tests that're used most common are the CT, or CAT scan, or MRI. The MRI is a little more sensitive in detecting different causes of dementia, particularly vascular causes. There are two other tests that I'll mention. One is called the PET scan, or positron emission tomography, and this is an approved test by Medicare to distinguish between Alzheimer's disease and frontotemporal degeneration.

There are certain requirements that're pretty easily available to find that must be met before Medicare will cover this, but it will cover it. And the last test I'm going to mention only because you'll hear more about that. And that is called the amyloid PET scan, which is able to identify one of the precursor abnormalities to the development of Alzheimer's disease. But currently, this is only being used for research purposes only. And it is not covered by Medicare or other insurances. Next slide, please.

So, once the diagnosis of dementia has been established, then, the disorder needs to be managed. And here, you need to work with the patients and their caregivers. It is a lifelong disease. There's no cure for dementia. And it has to be an individualized, patient-centered approach. Everybody who has dementia is unique. Early on in the disease, you really want to get the patient involved, particularly in determining preferences of who's going to speak for them. And as the disease progresses, it must rely much more on caregivers and family members.

The goal is to aim for the highest level of independence and self-determination for the person with disease that works for everyone. And here, works for everyone is very important, because what we see frequently is that everything is being done to try to preserve independence for the person, but all the caregivers are burning out. And eventually, that situation cannot be sustained. Next slide, please.

So, the principles of managing this disease. First of all, managing common challenging issues. One of the ones we see very frequently is getting people to stop driving. Another one that is commonly encountered is when the person needs to have additional help in the home or cannot live in their own home.

The second is to manage the symptoms of the disease. And these start generally with behavioral therapies, and then, if need be, drug management. Advanced care planning. Because this disease is relentless and progressive, most people who have this disease will come to the end of their life within about six to ten years. And the earlier you can plan for what the person's wishes are and keeping them involved in this, the better it is.

Care management and coordination. These people have complications both of their other medical illnesses and their dementia. Managing these other illnesses, that'll be important in caregiver support. Next slide, please.

Medications. The medications fall into two categories in terms of managing the disease. The first are cholinesterase inhibitors. And the trade names for these are donepezil, galantamine, and rivastigmine. There is a rivastigmine patch. All the other ones are oral. And they're all generic at this point.

The important thing, however, to remember is that the benefit of these drugs is very modest. It may be 10% improved, 20% it slows the decline, but does not prevent decline. And the remainder don't get much benefit at all. It appears to be valuable in most causes of dementia except for frontotemporal degeneration. And it actually may exacerbate some symptoms there. And then, finally, it's very important to know that these drugs have not been shown to prevent the progression of mild cognitive impairment to dementia. Next slide, please.

There is another drug that is available, which is called Memantine, which is also generic at this point. And it is approved only for moderate to severe Alzheimer's disease. The evidence behind it is not all that strong. And they have looked at combining it with a cholinesterase inhibitor. And once again, the benefit is not all that strong. Next slide, please.

So, there are a list, a long list, of drugs that have been tried and do not influence the course of dementia, and have not been helpful. I won't go through the entire list, but it has been a tremendous disappointment that we have not been able to develop new drugs that have been effective. Next slide, please.

So, managing behavioral and psychological complications. This is especially important. And there is good evidence for formal caregiver training. And you'll hear more about this from David Bass. Music therapy has some evidence behind it. Although, it's not all that strong.

And then, the other ones, such as cognitive stimulation, reminiscence therapy, pet therapy, these kinds of things, have very limited evidence when studied in trials. However, that doesn't mean that any given individual may benefit from this. So, there's a lot of things that can be tried. Some of them are just not evidence-based for the larger population. Next slide, please.

So, there are also drugs that're used. Antidepressants. There's some evidence that there's benefit to some of these on agitation, but it may actually cause the cognition to decline more quickly. There's a whole group of drugs called the atypical antipsychotics. These are quetiapine, and olanzapine, haloperidol, and et cetera. They're not very effective, but similar to other kinds of treatments, a few patients will benefit here and there. And for some of these patients, it's exceptionally beneficial. They do have high potential for side effects. They increase the risk of mortality. Essentially double it from about 2.5% to about 5%. So, you have to have these discussions with patients and their families.

Some other new drugs. There's a new drug called dextromethorphan-quinidine combination. One study showed some benefit, but it was once again modest. And then, there are a number of drugs, mostly anti-seizure drugs, that're used in the management of dementia. But there's little evidence for it. Next slide.

So, support for unpaid caregivers. I like to say that caregivers are the most important resource a person with dementia has. And about half of the caregivers will develop depression. The more educated they are, the more empowered a caregiver is, the better the care will be. And David Bass will talk more about this in just a moment. Next slide, please.

And you'll hear also from David and from Michelle Panlilio about some new models of comprehensive care for dementia. And these are models that focus not only on the caregiver, not only giving caregiver support, but also on making sure that the patient gets the most high-quality care. There are two big categories of these. One that're based in communities. Typically at senior centers. And you'll hear about the BRI Care Consultation models. And another one is a home-based model called MIND.

And then, there are health system-based models that reached out to the community. One of them is called the Indiana Healthy Aging Brain Center. And you'll hear more about the UCLA Alzheimer's and Dementia Care Program from Michelle.

So, at this point, I'm going to turn it over to David Bass. Next slide, please.

David Bass: Thank you, David. So, next slide, please. It's nice to be here with you. I'm from the Benjamin Rose Institute on Aging, which is both a community-based organization that provides services and a research organization.

And I'm going to talk about two related projects that extend what David began talking about in terms of support for caregivers as well as for the person living with dementia. One of them is Best Practice Caregiving and the other one is BRI Care Consultation. Next slide, please.

So, I'm going to start with Best Practice Caregiving. This is a tool that is being developed and just about ready for public launch. And this is a place where you'll be able to go to a website to compare and learn about 45 different evidence-based programs that support caregivers of people with dementia. And some of these programs also assist the person living with dementia. And these are non-pharmacological programs. Programs that aren't focused on medications or drug treatment.

Best Practice Caregiving is for professionals. So, this is a website being designed specifically for people, healthcare providers, social workers, nurses, all kinds of individuals who're professionals working with families. And it'll be a shopping interface, where you'll be able to go and compare evidence-based dementia caregiving programs just like you might go to a website to compare different models of a refrigerator to decide which one you might want to buy.

Best Practice Caregiving will have comprehensive profiles of each of these programs, detailed information about what it takes to implement these programs. That's really the focus of Best Practice Caregiving. Implementation characteristics. And I'll talk a little bit more about that.

You'll also be able to learn about experiences of sites that have tried these programs. Health systems, community organizations that have attempted to do a program. How is it working? What were their experiences? You'll be able to get complete bibliographies of all the published articles about each of these programs and the name of someone you can contact to actually get more information. And hopefully, the goal is to have more replications of these programs available in communities. Next slide.

Best Practice Caregiving is a collaboration between Benjamin Rose Institute on Aging and Family Caregiver Alliance. Our other partner is Katie Maslow, who's a visiting scholar at the Gerontological Society of America. And we have a team of great funders that're supporting this project. Next slide, please.

The reason we're doing Best Practice Caregiving is because right now, there is no single comprehensive updated source where you can go to easily find information about these programs that have been proven to be beneficial for caregivers and some of them also for the person living with dementia. So, you could go to the published literature in research journals and find information about these programs, but it's a bit difficult to find those articles, and there isn't a lot of information oftentimes about the implementation characteristics. Things like what kind of training do you have to provide to staff. What do the manuals look like for these programs? What kind of marketing tools are there to attract caregivers to use these programs?

So, research articles tend to be focused on the research findings. The lack of information from a single source makes it hard to know which program an organization might want to choose if it were considering adding a caregiver support program to what's offered. Next slide, please.

A major advance in the field, from our point of view, is that there are now many of these non-pharmacological programs that have proven benefits for family and friend caregivers. And some of them also benefit the person living with dementia. Despite these proven benefits, these programs are not widely available in communities. Most health and social service organizations don't offer any of these programs. And as a result, families can't access them.

There are a number of reasons why that's the case. One of the reasons is the lack of information about these different programs and the difficulty knowing how one program differs from another. So, Best Practice Caregiving is going to address that particular barrier. There are other barriers that limit program availability, like lack of a constant reimbursement source for these kinds of programs and stigma that keeps family members from reaching out for these programs, but those are really beyond the scope of what Best Practice Caregiving will do. Next slide, please.

Here are the eligibility criteria for programs to be included in Best Practice Caregiving. The first one is really the research basis for the program. So, there has to be a research study that shows statistically significant benefits for caregivers on at least one caregiver outcome. And it has to be published in a journal.

Number two is that the program also has to have been implemented in a community setting by a health or social service organization. So, we're looking for programs that have demonstrated they're feasible for a health system or a community agency to actually deliver. And finally, number three, there has to be somebody who you can contact in order to get permission or a license to deliver the program and all the delivery tools that might be needed. And it's amazing how hard it is to find the contact person to go to for lots of programs that show up in the research literature but really aren't available for community replication. Next slide.

Here is a list of programs that are going to be in the first, Phase I, launch of Best Practice Caregiving. There are 45 on this list, and we're hoping there'll be a Phase II where we'll be adding additional programs. Next slide.

Here's a list of the kind of the things these programs help with. And you'll see they are quite varied in the types of assistance provided. Some programs help with one thing. Some programs help with multiple things. And all of this'll be displayed in an easy-to-use fashion in Best Practice Caregiving. Next slide.

Here's a little bit more about the kinds of characteristics about programs that you'll be able to find in Best Practice Caregiving. Next slide.

So, Best Practice Caregiving is just about ready for launching, which is the culmination of a three-year project. The public launch of Best Practice Caregiving will be in fall of this year. And it will be part of the website of Family Caregiver Alliance, one of the partner organizations in the project. Family Caregiver Alliance has a great website and you can find that website at caregiver.org. And there'll be a place on that website where you'll be able to get at Best Practice Caregiving, the shopping interface for comparing different programs. And that'll launch later this fall.

So, I'm going to go on to my second topic, which is to really talk more about one of the programs featured in Best Practice Caregiving. And it's a program called BRI Care Consultation. It's a program that I was the lead developer for this program, which has been researched over the last 25 years here at Benjamin Rose Institute. And it's a care coordination/care coaching program, for both persons living with dementia and their family and friend caregivers.

It's also for people with other chronic conditions as well, but many of the studies and many implementations of this program are focused on people with dementia of one sort or another and their caregivers. It's been tested in ten different studies, and there are three research studies currently underway to further investigate this program and its effects on outcomes.

It's available now in communities by -- around 40 organizations are delivering this program as a regular service around the country. And that includes the services side of Benjamin Rose Institute. So, we actually deliver the program here in Cleveland. And other organizations, mainly health systems, area agencies on aging, Alzheimer's chapters, and other Alzheimer's-specific organizations are also doing this program. Next slide, please.

We created this program based on findings from research we had been doing here at Benjamin Rose that started in the late 1970s and continues today. But particularly in the 1980s and 1990s where we were surveying family caregivers and people with dementia about their experiences with accessing services and getting family members and friends to help in the way they wanted.

And we repeatedly would learn about key challenges that families were facing. Caregivers not knowing where to begin to find services, and trouble caregivers had with getting different family members to be on the same page, and know the best ways to help, and to coordinate help among family members and friends.

On the services side, repeatedly hearing about difficulties related to fragmentation among services, lack of coordination, not enough attention to prevention and planning. And caregivers would tell us too much assessment and not enough solution. They ask me the same questions over and over again, but I don't get any help.

There's also the problem families would talk about of the illness and the caregiving situations constantly are changing, but services fail to keep up with that change. So, kind of too static to adjust to the dynamic nature of this disease and caregiving. Next slide.

So, we developed BRI Care Consultation as a solution to those problems. It is a consumer-driven approach. That means that it is really designed to follow the lead of what family caregivers and people living with dementia want. The problems that are important to them drive this program.

It's a cost-effective program delivered by telephone, email, and regular mail. There are no in-person visits required. And it serves both a person with a chronic condition, including people living with dementia, and the family or friend caregivers.

Now, the program is very flexible, and it can be used by persons living with dementia who don't have a caregiver or don't need a caregiver. And they can be the sole recipient of the program. It

also can serve caregivers who are caring for someone who's too impaired or doesn't want to participate in the program. And the caregiver can use the program themselves. Or it can be for both people, and that's how the program was designed.

It is a personalized coaching program designed for simple and practical solutions. Establishes a long-term relationship with the family and the care consultant. And it is a standardized protocol that gives it -- its evidence-based, but the exact content of what kind of help each family gets is very personalized. Next slide.

These are the main types of assistance the program provides, the primary one being linking to and coordinating health and social services and helping to resolve barriers to accessing and using services that families face. It focuses a lot on involving family members and friends in the best possible ways, and provides emotional support and coaching for both the caregiver and the person living with dementia, if they're also participating in the program.

It provides lots of consumer-ready information to people. The program has over 700 vetted consumer-ready educational informational materials available to care consultants to distribute to families. And so, these are vetted materials. Families face increasingly saturation on information, especially online information on caregiving and problems with care. But the quality of that information is very variable. So, we've vetted materials to assure the quality of information that caregivers distribute. Next slide.

There are three main components to BRI Care Consultation, assessment, action plan, and ongoing support. I'll give you just a very quick summary of how the program deals with these. Next slide.

There is an assessment process, both initial and reassessment, but it is not a clinical assessment in the traditional sense. It really is designed to guide discussions between care consultants and families, and make sure that families have a chance to mention concerns or problems that might be on their minds. So, care consultants are required to cover a broad range of potential problems in these discussions. We do provide more standardized assessment tools that are optional, if care consultants want to use them. But these aren't required, and it's really about conversations with families and making sure that you prompt them to at least mention a concern, even if it's not foremost on their mind.

And it is very holistic. There are 24 domains of care that care consultants have to look at for the person living with dementia and 11 domains for the caregiver. And the first assessment is completed during the first four months. But it doesn't get away from the primary focus of actually addressing the things that families are most concerned about. And that starts with the very first call. Next slide, please.

And that starts with the action plan. So, at the very first contact, care consultants begin to try to help families find solutions to the problems that are important to them. And they do that by creating an action plan, which is comprised of simple, practical, baby steps that move people toward solutions to the things that're important to them. Those go into the action plan. And the

action plan is a list that grows. Action steps are added throughout the use of this longer-term program. Again, this is a long-term relationship.

And each action step has a specific person who's to complete the action steps, a date when it's expected to be completed, and care consultants call people to see how the work is going to complete action steps and help them adjust the plan as they encounter barriers to those action steps. Next slide, please.

This is an example of an action plan. We call it an action checklist. It's periodically sent out to families as they work with care consultants. So, as new action steps are added, care consultants mail or email caregivers and/or the person living with dementia the list of things they're supposed to do as well as the list that other people, other family members, professionals, including the care consultant, are supposed to do with the dates when they're expected to be done. And they're constantly updating the list that's sent to families and checking to see how accomplishing action steps is going. Next slide, please.

The program is a long-term program. And at the day of enrollment, a set of the minimum required contacts is set. The dates for those across time. So, care consultants are always required to be checking in with families. There are additional calls that can be initiated because they're following up on action steps. And caregivers or people living with dementia can contact care consultants whenever they want. Next slide, please.

Care consultants, with training, can have a bachelor's degree in social work, nursing, or other helping profession. And they are able to deliver the program effectively, managing caseloads of 75 to 125 families at a time. Next slide.

There is a web-based software system we developed to guide the delivery and assure the program is being done as it was intended according to the evidence base. Next slide.

This slide just shows you a few of the kinds of outcomes that we found in the different research studies, including reduction in emergency department use and hospitalizations by the person living with dementia. Next slide.

I'll pass now to Michelle for the next part of the agenda.

Michelle Panlilio: Thank you, Dr. Bass. Good morning, everybody. My name's Michelle Panlilio, and I'm a Nurse Practitioner. I'm also one of the Dementia Care Specialists at the UCLA Alzheimer's and Dementia Care Program.

So, for my segment of this webinar, I'm going to be talking about the health system-based care programs and taking care of patients with dementia. There will be some details that I will not be able to cover due to time constraints. However, I will try to do my best to be clear about the topics at hand. For the purposes of this program, I will be referring to individuals with dementia as patients. Next slide, please.

So, care programs taking care of patients with dementia that are implemented in the health system typically include the following. So, it's usually led by a physician or a nurse practitioner. Patients are seen face to face for annual visits. And the coordination of their care occurs within the medical system by using electronic health records.

During these visits, we write for orders. They may be for medications, equipment, or sometimes referrals to other specialties. Two examples of such programs are the Indiana University Healthy Aging Brain Center, the HABC, and my program, which is The UCLA Alzheimer's and Dementia Care Program, UCLA ADC. Next slide, please.

So, our program began in 2011 after we received some philanthropic funds. We had originally planned to enroll 250 patients. However, a year after we started the program, we received a CMMI Award, and this allowed us to expand the program to 1,000 patients. So now, over eight years later, we've been able to serve over 2,600 patients and their families, with currently 700 active patients. The goals of the ADC program are to maximize patient function, independence, and dignity, while trying to minimize caregiver strain and reduce unnecessary costs. Next slide, please.

For patients to be eligible to be in our program, they must have a diagnosis of dementia, and they must live outside a nursing home. Patients must be referred into ADC by a physician who's willing to partner with a dementia-care specialist. Lastly, but most importantly, they need to have a family member or a caregiver who is willing to participate in the patient care.

The philosophy that we have taken is that we approach the patients and caregivers as a dyad. So, both need support. This is something that I talk about during the very first appointment in that I'll mention something along the lines of, "You know, Mrs. Smith, you are my patient. However, you only count for half of the package. The other half of the package is the people here in this room, which are your caregivers."

As a program, we recognize that the care for patient's dementia is a long journey, and you can have good days and bad days. A large component of our program is that, although we do care for our patients within the UCLA health system, we also rely very heavily on our community-based organizations, our CBOs, and I'll speak more about them later on in this presentation. Next slide, please.

So, once a patient is referred to the dementia care program, the dementia care specialists do not assume primary care of the patient. We only assume the dementia care for that patient and that family. The primary care doctors and the geriatricians will stay the same. Next slide, please.

The initial assessment is probably the most important appointment that we have with that patient. It's quite lengthy. It'll go anywhere from 90 minutes up to 2 hours. And I've been asked so many times, "What could you possibly talk about in 2 hours while you have a patient with dementia in the room?" And it doesn't surprise me anymore how quickly that time goes, because everybody is really involved in the discussion. The patient, the caregivers, and ourselves. Sometimes there are multiple family members.

So, during the initial assessment, we will talk about the dementia history. We will perform a physical and mental status exam. By caregiver, I meant paid or unpaid caregivers. So, part of that initial assessment is we will discuss their current concerns. That may be related to medications, behaviors, or patient safety. And it's important to address those concerns, because many times, their concerns may be different from ours.

Part of that appointment is that we will assess the resources. So, who are the people who're responsible for their medical care? Who is responsible for managing their finances? Who is giving them their medications? And how are they getting to appointments? Part of that assessment also includes financial assessment. And although at that point I might have known that patient and their family for maybe about 20 minutes or 30 minutes, most patients are willing to divulge that information. I usually preface those questions by saying, "It's my job to help you plan for your future." And I will say, "Where do you see yourself in about six months? Where do you see yourself in two years?" And, "As your dementia care specialist, how can I help you get there?"

Another segment of that appointment is that we will discuss advance care planning. We ask for the patients and the caregivers to bring their advance directives, but if they don't have one, we'll help them fill one out, or at least get the discussion started on who they would like to make medical decisions for them on their behalf if they're not able to. Part of that appointment, we also talk about the POLST for advance care planning, which is the Physician's Orders for Life-Sustaining Treatment. That can take some time.

Part of that assessment for us dementia care specialists is although we are doing an assessment of the patient, we also do an assessment of the caregiver and the family members, and how they interact with each other. So, we try to determine just how much education and how much support they're going to need. And if they need any, what is the best way of learning for them? Is it through books, videos, counseling, or courses? Next slide, please.

Once we see our patients for the initial appointment, we will assign them to a particular acuity. This, for me, is very important, because it determines my day-to-day schedule and who I will be contacting on that particular day.

So, for red patients, these are patients that have had two or more ER visits or hospitalizations in the past six months. Some of these patients may have uncontrolled or problematic behavioral issues that may result in inpatient psychiatric hospitalizations. Red patients are called at least once a month.

Yellow patients are those patients who have been in the ER or been hospitalized once in the past six months. And these patients may have new or worsening behavioral issues. Follow-up calls for our yellow patients are done at least once every two months.

For our green patients, this is the majority of our patients. And these are the patients that are coasting. They're stable. No behavioral issues and no ER visits or hospitalizations in the past six months. These patients are called once every three months, at minimum. Next slide, please.

So, as far as ongoing care, aside from the calls and the emails they get from us depending on their acuity, we see them on an annual basis in person, both with the patient and the caregiver in the office. If something happens, and they manage to end up in the emergency room or in the hospital for any reason, we, as dementia care specialists, are notified immediately by using the electronic medical record. And at that point, it would be our policy to call them. Call the family, and make sure that they're okay, and contact the current medical team at the hospital, and offer them any of our assistance. Next slide, please.

I had kind of alluded earlier on how heavily we rely on our CBOs, our community-based organizations. When we started the program, we identified several local CBOs that we thought would provide beneficial services to our patients and the caregivers in our program. We identified key personnel within each CBO, and we made formal introductions to key staff.

And as new employees, we do spend some significant time visiting each site and obtaining a list of their services provided by each CBO and the cost of each service. During that time, we also try to attend one of the events and see if they are appropriate for any of our patients, depending on their stage of dementia.

Over the past few years, we have developed a voucher program. And I think the easiest way that I can describe that is you can consider it as a gift certificate of some sort, where it will pay for some of the services, whether it be for the patient or the caregivers. And our program will provide these vouchers at the discretion of the dementia care specialists. Next slide, please.

So, on this slide are some of the services that are provided for our patients and the caregivers by our CBOs. For the patients, they do provide adult daycare and some programs for enhancing brain health. For our families and our caregivers, they provide counseling, case management, support groups. There're a couple that provide legal and financial counseling. And most of them do provide some sort of education, whether it's through workshops, classes, handouts, or webinars, like this one. Next slide, please. On this slide are some of the CBOs that our organization partners with. Next slide, please.

I won't go into detail with this in the interest of time, however there are two -- I just wanted to identify two common barriers for patients and caregivers when working with CBOs. And this is something that we've learned over time. I think Dr. Bass alluded to several of these when he spoke earlier.

So, one of the main barriers for our patients is that there's no specific contact person or a number provided for the CBO. It's not enough for any of us to recommend that, "I think you should contact the Alzheimer's Association. Here's their 800 number." What we've found through our program that works is that we will give them a warm handoff to whoever's the director, and give a direct number and a full name for that person that they need to contact.

Another barrier that I would like to discuss is majority of the time, the caregivers and the families are simply not knowledgeable about the services that are being provided at the facility. So, I think it would be beneficial, at least my experience, whenever we are recommending services, try

to make it a specific service instead of something that's generalized, that's appropriate for that particular patient and their stage of dementia as well as the family members.

So, for example, it would be more appropriate to say, "I think you should call Ms. Anna Smith, and this is her phone number. This is her direct number and her email. And the program that I would like for you to sign up is called Music Mends Minds." Next slide, please. On this slide are some other common barriers for patients. Next slide, please.

So, part of our work with our CBOs is that we do maintain continuous contact with them. Most of my CBOs communicate with me on a daily basis through emails or phone calls about our program. However, twice a year, we do have a steering committee and during that time, the UCLA ADC key personnel as well as the directors and other key personnel of our CBOs get together at UCLA and we have meetings that are about an hour, hour and a half each time. And during that time, we will talk about any program updates, any awards, achievements, future goals, or any introduction of new staff. Next slide, please.

Patients in the ADC program, I will cover this very quickly. They score about a 17.4 out of 30 when they're doing the Mini-Mental Status Exam. This falls under the moderate to advanced stages of the disease. For our caregivers, about 60% of them are the children of our patients, and 40% of them are the spouses of our patients. Next slide, please.

So, I wanted to spend a little bit of time talking about our caregivers in the program. At baseline, about 14% of them report severe depression. And again, these are people who're taking care of patients with dementia. So, I think that's important to address. About 36% of them report high stress levels. 80% of our caregivers at baseline reported that although the patient's doctor understood how dementia and behavioral problems complicate other health conditions, only 26% of them reported that they had a health professional who could help them about dementia-related issues. Next slide, please.

Caregiver satisfaction with ADC. So, caregivers, we have found, like our program very well. Anywhere from 90% to 92% have reported that they felt that their concerns were listened to and that their time was well spent; 92% would refer the program to others. Next slide, please.

At the one year outcome, caregivers in our program report that their distress from the patient's behavioral symptoms were significantly reduce, their overall strain was less, and that their depressive symptoms were reduced. Next slide, please.

At our one-year timeline, at that time, we have had about 279 referring physicians, and they like this. About 61% of them reported that we provided valuable medical recommendations, and about 85% said that the program made valuable behavioral recommendations. 90% of our referring physicians would recommend the care to other patients. Next slide, please.

So, at the two-year timeline at ADC, our patients were found to have a 20% reduction in emergency room visits, a 21% reduction in ICU stays, a 26% reduction in hospital stays, and an overall reduction of 40% less nursing home facility placements.

Thank you so much for your attention. At this time, I will be turning you over to one of our caregivers in our program, Ms. Ann Cheslaw.

Ann Cheslaw: Thank you, Michelle. Hello, I'm really grateful to have the opportunity to speak with you today. You're the people on the frontline who offer families like mine compassion and guidance in navigating the dementia path with someone we love.

As providers, you know how emotionally complicated and intensely personal our journeys are, and recognize, often way before we do, that we will be called to muster up our resilience, have all kinds of faith in ourselves, and whenever possible, we'll need to manage to keep a song in our hearts.

So, it's my hope that in the next ten minutes as I share my mother's story, I can concurrently offer you a few insights that might prove helpful as you work to make things easier for people like me. Next slide, please.

My brother, sister, and I were really lucky kids. We grew up in a home that was always filled with my father's teaching us about patience and the reach of history, and my mother's sweetness in song. My earliest memories are of her singing, I'm a Little Teapot, Puff the Magic Dragon, Take Me Out to the Ballgame. These were all part of her happy repertoire.

When we were young, our parents joined the Department of States Foreign Service. We traveled the world changing countries and cultures every two to three years. If you can imagine the transitions between post required tremendous adaptability. And while exciting, these could also be daunting.

Dad had headed US Diplomatic missions. Mom was deeply entrenched in communities where she did purposeful volunteer work. From caring for lepers in the high hills of Malaysia to offering family planning support to the poorest of the poor in Bangladesh to hosting heads of state across the globe, mom's warmth and energy were her trademarks. I remember how proud I felt when I heard from one country's president that, "Parties do not start without your mother."

Midway through their career, mom returned to Washington on home leave. She was in her later 50s, and I noticed that she was repeating ideas a lot. She'd pose questions about things she'd experienced overseas. "Have you seen an (inaudible) lately, Ann?" she'd ask, referring to indigenous people in Asia, as an example.

She'd misplace things, and to cover her embarrassment, she'd say she actually forgotten she'd actually put them away for safe keeping. I was concerned and took her to a doctor. He ran some tests. And after talking with mom for a short while, assured me that while she was very healthy, she was exhibiting signs of repetitive aphasia. I had no idea what that clinical label meant. All I cared about was that she was not ill. I hadn't a clue what to ask him, and the internist did not offer or volunteer anything edifying.

Over a decade later, mom and dad completed their overseas tours of duty. Now, stateside, and with us kids watching, we noticed that mom could not remember how to make her legendary

American apple pie. Setting the table and flower arranging, part of her well-honed diplomatic training eluded her. She withdrew from vigorous conversations. Reading, a forever passion, no longer captivated her. Yet, clear as a bell, and holding one of our hands, she'd belt out, Que Sera Sera. You all know the refrain, "Whatever will be, will be."

None of us kids realized what significance those lyrics were starting to have in our lives. While in their 90s, our father, and mother's beloved husband for just short of 71 years, died. We kids recognized that dad had actually been compensating for her in myriad ways. He'd kept their social calendar, finished her sentences, and prompted her through more daily tasks than we'd realized. Without dad, mom became very confused. We three kids hadn't a clue what to anticipate in the short-term or what to do in the long-run as mom's grief at the loss of dad intensified.

Mom was also now very socially isolated. We talked about bringing her to live with one of us, but we each were working. We moved her to a nearby assisted living facility where we hoped she'd find some kind of joy again, but that didn't happen. It became clear that this was now the most foreign place she'd ever lived.

In this new territory, we watched mom circulate from table to table to try to facilitate friendships, but some of the residents were less than kind. This was deeply, deeply painful for me. I felt I could not protect her, and I also felt very guilty about not having moved her in to live with me.

At that time, I'd heard about a special geriatrician at UCLA nearby who was known for her expertise in dementia care, and I took mom to meet Dr. Grace Chen. Before Dr. Chen met mom, she asked me what mom loved to do. You can guess my first response. When Dr. Chen introduced herself and asked mom how she was feeling, mom looked at her and sang, "You are My Sunshine." And instead of being dismissive or shying away from this moment, Dr. Chen joined mom in the next line of the song. "You make me happy when skies are gray."

Over the course of the next year, and while mom was receiving superior medical care, I was really struggling with her increasingly identifiable dementia. I was scared by her occasional outbursts regarding her desire not to live. She would tell me that she had no purpose. I felt hopeless and inept. I thought if I spent more time with her that maybe I could both control her safety and slow down her demise. I became what some would call a helicopter parent to my mom as she was becoming an adult child.

And at that point, Dr. Chen made it clear that while it was important to diagnose the patient with dementia, it was equally important for her to provide us kids, and yes, especially me, with a kind of treatment plan as we coped as a family unit with how to be there for mom, wherever that was in any moment.

We joined UCLA's Alzheimer's and Dementia Care Program that provided a patient- and family-centric culture of care. You've just heard about that. Mihae Kim became our assigned Nurse Practitioner and Care Manager, and we did have that initial conversation Michelle talked about a few minutes ago.

Mihae also extended our education on Alzheimer's in ways that complemented our immersive experience. As importantly, she knew she had to get us three kids on the same page about caring for mom. To that end, she helped us establish differentiated roles.

My sister, in addition to visiting mom, took on all the bill paying and legal side of things. I took on the primarily medical liaison responsibilities. And because I was now retired, spent a lot of time with mom daily. My brother, who lived in London, would fly in when he could, and also served as the long-distance negotiator when issues needed mediating.

As mom's disease progressed, my dis-ease became more obvious. My struggle about our family's impending second loss heightened, and the anticipation of losing another patient was anguishing. I hadn't even had time to mourn the loss of dad.

Thankfully, the ADC program directed me to a community support group right near my home, and also provided vouchers allowing me free access to a therapist in whom I could confide. I cannot overstate the immense relief and perspective that these resources offered me.

There came a time when we needed to move mom to the Alzheimer's wing in the facility. There, she was encouraged to sing freely, dance, grow flowers on their terrace garden, and even set tables in the small dining room. Mistakes didn't count. She could hold and talk to the resident cat or life-sized baby doll. But after about six months, and although her eyes lit up whenever we were with her, she stopped wanting to speak, or eat, or participate in almost anything.

Dr. Chen and Mihae encouraged us to bring in hospice. And because they knew mom so well, they pointed us to a provider that had a singer-guitarist come play to her as she slowly slipped off to that silvery, silvery moon place she previously sung about.

I cannot explain how quiet things got for me without mom's song, but the remarkable geriatrics and ADC teams would check in. Their notes, and calls, and yes, they're reminding me of mom's voice, providing a continuity of caring something every family member wishes for, I'm certain.

I learned so much from this journey with mom, and I offer my five top lessons to you in case you want to share these with others. Slide, please.

One, encourage family members, especially those with genetic disposition to Alzheimer's, to work with a geriatrician sooner rather than later. Help them select a practitioner who is also a teacher and one who values the patient's individual life's narrative as part of his or her wellness.

Two, understand that caregivers don't have time to seek out community resources and educational tools to help them learn. Direct them to these, please. Online videos and podcasts, rather than reading materials are ideal. There need to be so many more. Slide, please.

Remind family members that this disease is not linear. As Dr. Reuben said, this disease is relentless and progressive. Let them know that their frequency in showing up at living facilities, nursing homes, and in hospitals often correlates with the improvement and increase in

personalized care their loved one gets. Being seen as actively advocating and present gets noticed by hospital and facility staff members.

Four, assure family members that self-care is critical as they cope with their own predictable senses of isolation, inadequacy, fear, and anxiety about the future. And finally, slide, please, urge caregivers to remember to sing, regardless of how off key they may be.

Again, and on behalf of those who are or who have been on this long journey with a family member, thank you for all that you do help us find rainbows on even the foggiest of days.

David Reuben: So, to wrap up the presentation part, I'd like to make five final points. The first is the number of persons with Alzheimer's disease and related dementias is rising rapidly as us baby boomers age.

In the future, there may be better methods to identify and modify risk, prevent the development of dementia, and treat the dementia. But currently, the care of dementia relies on detection, mediations that only have modest effectiveness, and support, including caregiver training and support, case management, and care coordination.

There are many, many effective models, particularly as David Bass mentioned. They're available but have not been widely adopted. And finally, every dementia story is unique and has multiple victims; the person with the disease and the caregivers.

So, we'll turn it back over to the Lewin Group.

Caroline Loeser: Great. Thank you, everyone. And Ann, we just wanted to say thank you so much for sharing your story. It was incredibly captivating, and moving, and we really appreciate that you spent the time to share your story with us.

And of course, a big thank you to all of our faculty. Dr. Reuben, Dr. Bass, and Michelle. This has been incredibly informative. And thanks so much for joining us today.

With that, we have a few minutes for questions from the audience. So, at this time, if you have any questions for our speakers, please submit them using the Q&A feature on the lower left of the presentation. Type your comments at the bottom of the Q&A box, and press Submit to send it.

Great. So, we did get quite a few questions throughout the presentation. Ann, I'll start with a question for you that came up during your portion. How can providers support family members whose loved ones just received the diagnosis?

Ann Cheslaw: For me, I would say that just finding a doctor who can really talk through what your options are becomes critical. It's sort of like an orchestra leader. You need one person to kind of help you find a way to develop your rhythm and find a way to synchronize things. It's very, very critical that that person is -- not only informs you about the disease, but helps you find information about where to go and what you can do next.

So, pairing up with a team for us, like UCLA, was absolutely critical. Because we had no idea, as Dr. Bass was alluding to earlier, what the resources out there were, who to talk to, and the levels of care that we all would need.

Caroline Loeser: Thank you, Ann. Great. We have another question here. I think Dr. Reuben or Michelle, or Dr. Bass, really, any of you could speak to this. The question is, how do you ask questions to assess memory for individuals who come from different cultural backgrounds, or for whom English isn't their first language? For example, the questions about US politics and JFK wouldn't be relevant for certain populations.

David Reuben: Right. I'll take this, because it's a challenging issue. Obviously, to test for memory that both the examiner and the person who's being tested have to have the same memory bank. They have to have the same experiences.

And many times, what I will do is I will either talk to the family about things that they should know about, the person should know about, and ask about those generally with a translator so that I'm dealing with information they should know about, and to try to make it culturally and personally specific.

But obviously we have people who have migrated here after the Kennedy assassination or just for some other reason don't know the answers to these things. And then, you have to have something that could be shared knowledge. Something that they would know about that you would know about.

Caroline Loeser: Great. Thank you, Dr. Reuben. And we have another question that I think you could address. And this one is about de-prescribing medications. Would you agree that perhaps the pharmaceutical intervention worth focusing on would also include de-prescribing other medications a person may be on to simplify or reduce contraindication risk versus adding some of the dementia-focused drugs to the mix?

David Reuben: Yeah, de-prescribing or taking away drugs is very important in two contexts. Actually, three contexts. One is that sometimes these other medicines may have side effects that actually worsen cognition. So, sometimes like bladder relaxants may have effects on cognition.

Second, it simplifies the regimen. And so, both for the caregivers or if people who have early-stage dementia are still taking their medicines, that it makes it easier for them to take it. And finally, sometimes because of the limited lifespan expectancy of these people, they don't need all these medicines. So, if somebody is getting to the end stage of dementia, they really don't need to have medicines to lower their cholesterol. So, de-prescribing's an important component of good dementia care.

Caroline Loeser: Great. Thank you. Dr. Bass, oh, I'm sorry. Was there someone else who wanted to make a comment? Okay, maybe that was background noise. Dr. Bass, there were quite a few attendees in the Q&A who shared interest in the Best Practices Caregiving website. One

person in particular asked if there'll be a marketing launch to allow others to know when BPC is available for public use?

David Bass: Yes, we are planning a multifaceted marketing campaign to get the information out about this. We know it's so important to get this website used. So, I'm hoping that everybody on the call will hear about it and know when it's launched. But if not, I'm always available to be contacted for more information.

Caroline Loeser: Okay. Thank you. All right. Well, at this time, if you have any additional questions or comments, please email RIC@lewin.com. For more information, we have additional resources here on this slide, including a link to Alzheimer's Los Angeles's website, videos about caregiver education, and resources from the National Alzheimer's Project Act.

Please also visit the Resources for Integrated Care website for more information on this topic, including tip sheets and additional resources related to Alzheimer's disease and other related dementia.

The slides for today's presentation, a recording, and a transcript will be available on the Resources for Integrated Care website shortly. As a reminder, additional guidance about obtaining credits and accessing the links to the post-test can be found within the Continuing Education Credit guide in the resource guide on the left-hand side of your screen or at the Resources for Integrated Care website.

Thank you so much for joining us today. Please complete our brief evaluation of our webinar so that we can continue to deliver high-quality presentations. If you have any questions for us, please email us at RIC@lewin.com. Thanks again to all of the speakers, have a wonderful afternoon, and thank you so much for your participation.